State of Delaware: Highmark First State Basic

Coverage Period: 07-01-2013 through 06-30-2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs. **Coverage for:** Individual/Family **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.highmarkbcbsde.com** or by calling **1-800-633-2563**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network $500 Individual / $1,000 Family; Out-of-Network $1,000 Individual / $2,000 Family; deductible does not apply to preventive services, prescription drugs or any service with a copay.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. In-Network $2,000 Individual / $4,000 Family; Out-of-Network $4,000 Individual / $8,000 Family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, **deductibles,** balance-billed charges, any copays, prescription drug copays and health care services this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket** limit.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. Go to www.Highmarkbcbsde.com or call 1-800-633-2563 for a list of in-network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed in the section ***on page 5***, below. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000 and you have met your deductible, your **co-insurance** payment of 20% would be $200. This may change if you haven't met any of your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in network providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	None
	Specialist visit	10% coinsurance	30% coinsurance	None
	Other practitioner office visit	10% coinsurance for chiropractic care	25% coinsurance for chiropractic care	Coverage is limited to 30 visits per plan year for chiropractic care
	Preventive care / screening / immunization	No Charge	30% coinsurance	Coverage is limited by age, gender and risk parameters as identified in Highmark Delaware's Preventive Health Guidelines. Refer to your Summary Plan Description (SPD) for specific information.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT / PET scans, MRIs)	10% coinsurance	30% coinsurance	Prior authorization required. Failure to pre-authorize will result in a denial.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.express-scripts.com**	Generic drugs	$8.50 copay for 30-day supply retail or mail order; $17 copay for 90-day supply participating retail or mail order	Reimbursement limited to in-network allowable amount minus applicable copay	Up to 30-day fills at retail or mail order for non-maintenance drugs; 90-day fills for maintenance drugs available at participating pharmacies or mail order only, maintenance drugs filled as 30-day supply incur penalty at fourth fill; under Choice Program you pay applicable co-pay plus difference between generic and brand when generic equivalent is available.
	Preferred brand drugs	$20 copay for 30-day supply retail or mail order; $40 copay for 90-day supply participating retail or mail order	Reimbursement limited to in-network allowable amount minus applicable copay	
	Non-preferred brand drugs	$45 copay for 30-day supply retail or mail order; $90 copay for 90-day supply participating retail or mail order	Reimbursement limited to in-network allowable amount minus applicable copay	
	Specialty drugs	Co-pay based on whether drug is generic, preferred or non-preferred	Not covered	First fill can be at retail; future fills must be through specialty pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician / surgeon fee	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room services	10% coinsurance	10% coinsurance	Care must be rendered within 48 hours of onset of symptoms.
	Emergency medical transportation	10% coinsurance	30% coinsurance	None
	Urgent care	$25 copay	$25 copay	None
If you have a hospital stay	Facility fee (e.g. hospital room)	10% coinsurance	30% coinsurance	Prior authorization required. Failure to pre-authorize will result in a denial.
	Physician / surgeon fee	10% coinsurance	30% coinsurance	Prior authorization required. Failure to pre-authorize will result in a denial.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	10% coinsurance	30% coinsurance	None
	Mental / Behavioral health inpatient services	10% coinsurance	30% coinsurance	Prior authorization required. Failure to pre-authorize will result in a denial.
	Substance use disorder outpatient services	10% coinsurance	30% coinsurance	None
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance	Prior authorization required. Failure to pre-authorize will result in a denial.
If you are pregnant	Prenatal and postnatal care	10% coinsurance	30% coinsurance	None
	Delivery and all inpatient services	10% coinsurance	30% coinsurance	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Coverage is limited to 240 visits per plan year. Prior authorization required. Failure to pre-authorize will result in a denial.
	Rehabilitation services	10% coinsurance	30% coinsurance	Applied Behavioral Analysis limited to $36,000 per person per plan year to age 21.
	Habilitation services	Not Covered	Not Covered	No coverage for habilitation services.
	Skilled nursing care	10% coinsurance	30% coinsurance	Coverage is limited to 120 days per benefit period. Benefits renew after 180 days without care. Prior authorization required. Failure to pre-authorize will result in a denial.
	Durable medical equipment	10% coinsurance	30% coinsurance	None
	Hospice service	10% coinsurance	30% coinsurance	Coverage is limited to 365 days.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	None
	Glasses	Not Covered	Not Covered	No coverage for glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Care by Family Members
- Care in Residential Facilities
- Cosmetic Surgery
- Custodial Care/Rest Homes
- Dental Care
- Experimental/Investigational Care
- Glasses
- Habilitation Services
- Long-Term Care
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- Worker's Compensation Claims

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic Care
- Hearing Aids (up to age 24)
- Infertility Treatment
- Inpatient Private-Duty Nursing
- Non-emergency Care Outside US

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-633-2563. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

- Highmark Blue Cross Blue Shield Delaware: 800.633.2563, or www.highmarkbcbsde.com.
- Additionally, a consumer assistance program can help you file your appeal. Contact The Delaware Department of Insurance /Consumer Assistance Program: 841 Silver Lake Blvd, Dover, DE 19904, or 302.674.7300(local), 800.282.8611(toll free), or consumer@state.de.us.

Language Access Services:

- Spanish (Español): Para obtener asistencia en Español, llame al 1-800.633.2563.
- Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800.633.2563.
- Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-800.633.2563.
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800.633.2563.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use the examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

Amount owed to providers:	$7,540
Plan pays	$6,190
Patient pays	$1,350

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Co-pays	$10
Co-insurance	$680
Limits or exclusions	$150
Total	**$1,340**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

Amount owed to providers:	$5,400
Plan pays	$1,780
Patient pays	$3,620

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Co-pays	$340
Co-insurance	$190
Limits or exclusions	$40
Total	**$1,070**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no medical expenses for any member covered under this plan.
- Out of pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller the number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.